TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Angela Skrabanek, OTR.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-2998-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 31, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… Designated Doctor requested FCE."

Amount Sought: $846.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "That complaint process is the appropriate administrative remedy to address fee and payment matters related to health care certified networks…This claim is in the Texas Star Network…Texas Mutual relies on the above and all of the denial reasons noted on the EOBs and requests a resolution in its favor."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount Sought	Amount Due
July 27, 2015	Functional Capacity Evaluation (16 units)	$846.24	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement for the service in dispute.
3. 28 Texas Administrative Code §127.10 sets out the procedures for designated doctors.
4. Texas Insurance Code §1305.003 sets limitations on applicability of Texas Insurance Code Chapter 1305.
5. Texas Labor Code §408.0041 grants the Division of Workers' Compensation the authority to order designated doctor examinations.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A07-Documentation does not meet the level of service required for FCE per rule 134.204(G)3(C).
   - CAC-150-Payer deems the information submitted does not support this level of service.
   - CAC-W3 – In accordance with TDI-DWC Rule 134.804. This has been identified as a request for reconsideration.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 350 – In accordance with TDI-DWC Rule 134.804. This has been identified as a request for reconsideration.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Does the network complaint process apply?
2. Are Texas Mutual's documentation-based denials supported?
3. Is reimbursement due for the FCE in dispute?

Findings

1. This medical fee dispute was filed by Angela Skrabank, OTR. The health care provider is seeking $846.24 from Texas Mutual for a Functional Capacity Evaluation (FCE) performed at the request of designated doctor (DD) Michael Mann. TMIC explains in its response to medical fee dispute that:

   > The complaint process is the appropriate administrative remedy to address fee and payment matters related to health care certified networks…This claim is in the Texas Star Network".

   The referral for the FCE in this dispute was made by a designated doctor. Such referrals are authorized under the Texas Labor Code and division rules. Texas Insurance Code Chapter 1305 contains a provision which limits applicability of certain 1305 Network requirements when they adversely affect powers granted to the division under the Labor Code.

   Texas Insurance Code §1305.003 titled LIMITATIONS ON APPLICABILITY states that:

   > (a) This chapter [TIC 1305] does not affect the authority of the division of workers' compensation of the department to exercise the powers granted to the division under Title 5, Labor Code, that do not conflict with this chapter [TIC 1305].

   Texas Labor Code §408.0041 grants the division the exclusive authority to order a designated doctor to examine any injured employee and resolve questions or disputes over the injured employee's medical condition. 28 Texas Administrative Code §127.10 in turn authorizes designated doctors to make referrals when necessary to resolve the question(s) the designated doctor was ordered to address.

   Because the FCE was performed as a result of a designated doctor referral, and because this is a power that is granted exclusively to the division under the Labor Code, the appropriate remedy for review of a medical fee dispute over a referral exam is the division's medical fee dispute resolution process. The Division finds that TMIC's position is unsupported.

2. Texas Mutual asserts other defenses on its explanation of benefits that "A07-Documentation does not meet the level of service required for FCE per rule 134.204(G)3(C)."

   On the disputed date of service, the requestor billed CPT code 97750-FC.

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

   The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed".

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(3) Functional abilities tests, which include the following:

(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill."

A review of the FCE report finds that the report does not document testing using a stationary bicycle or treadmill; therefore, the requestor documentation does not contain the required elements established in 28 Texas Administrative Code §134.204(g). As a result, the respondent's denial is supported and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		02/16/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.